

Montana Central Tumor Registry

Newsletter



MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Lung Cancer Rates Decline Nationwide

Report shows a continuing decline among men, and a promising decline among women

Lung cancer is the most commonly diagnosed cancer and the leading cause of cancer death in the United States. Most deaths from lung cancer are caused by cigarette smoking and exposure to secondhand smoke. Large variations in lung cancer, smoking behavior, and tobacco control programs and policies have been observed among states. Effective tobacco control policies can decrease smoking prevalence, ultimately leading to decreases in lung cancer. To assess lung cancer incidence by state, CDC analyzed data from the National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program for the period 1999-2008. To assess smoking behavior by state, data from the Behavioral Risk Factor Surveillance System (BRFSS) for the period 1994-2009 were analyzed. This report summarizes the results of these analyses. From 1999 to 2008, decreases in lung cancer incidence were observed among men in 35 states and among women in six states. Regionally, the lowest rates and most rapid rate of decline in lung cancer were concentrated among states in the West, correlating with low smoking prevalence and high ratios of former smokers to ever smokers. Further reductions in smoking prevalence are critical to continue the decline in lung cancer incidence.

Cigarette smoking causes lung cancer in men and women. Wide variations in state tobacco control efforts, smoking prevalence, and lung cancer incidence have been observed in the United States. Lung cancer incidence has been decreasing for the past several decades among men but not among women.

Lung cancer incidence is beginning to decrease among women and is continuing to decrease among men in most states. Lung cancer rates are declining more rapidly in the West, which corresponds with smoking behavior; states with low smoking prevalence and high quit ratios are concentrated in this region.

Decreases in lung cancer incidence provide compelling evidence for state tobacco control policies, such as increasing tobacco excise taxes, enacting smoke-free laws, and funding policies to assist smokers in quitting. To continue these decreases in lung cancer incidence, current tobacco control funding for states needs to be increased to implement and sustain successful programs to reduce cigarette smoking and secondhand smoke exposure.

Source: CDC/MMWR September 16, 2011

Cancer Surveillance & Epidemiology Program Staff

Laura Biazzo, MPH
Program Manager
(406) 444-0064
lbiazzo@mt.gov

Debbi Lemons, RHIA, CTR
Coordinator, Montana
Central Tumor Registry
(406) 444-6786
dlemons@mt.gov

Diane Dean, MS, CTR
Data Control Specialist
(406) 444-6710
ddean@mt.gov

Paige Johnson, BS, CTR
Data Control Specialist
(406) 444-6709
paigejohnson@mt.gov

Valerie Weedman
Logistics Coordinator
(406) 444-5442
vweedman@mt.gov

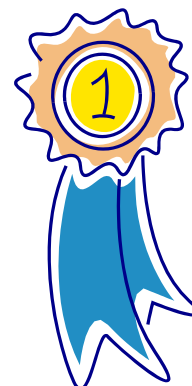
FAX: (406) 444-6557

www.cancer.mt.gov

Contest!

The first registrar to correctly answer the following trivia questions and submit responses to Debbi Lemons (dlemons@mt.gov) will win a prize!

1. What month and year was the MCTR Newsletter initiated?
2. What are the top 4 cancer sites?
3. What is the Montana Central Tumor Registry's reference year?
4. What does FORDS stand for?
5. What is the international symbol for cancer?
6. What are the three most common tumor markers done for breast cancer?
7. How many new cancer cases are reported to the MCTR each year?
8. What is the most preventable cause of cancer?
9. What is another term for a tumor that is not malignant, not invasive, generally harmless?
10. What is the term used to describe the return of a cancer that after a disease-free interval?



CS V02.04: Why, How, and When?

For registrars and registry managers wondering what's next for Collaborative Stage (CS), this brief communication will provide an update on where things stand and what to expect in the next few months. The upcoming release is designated CS V02.04.

During the 2010 implementation of CS V2, information from the registry community flowed in through CANSWER Forum of the American Joint Committee on Cancer (AJCC). In addition, the Surveillance, Epidemiology and End Results (SEER) Program conducted reliability studies in all its registries to provide data on coding accuracy and consistency. All of this information was fed back to the CS Mapping Team, which has implemented the following types of changes:

- Clarification of coding, which includes notes added to problem areas.
- Corrections to mapping errors, for example in MelanomaSkin, lymph node staging now takes into account whether the information is based on clinical or pathological information.
- Improvements in mapping, for example, thyroid will now include the "(s)" or "(m)" designation for T.
- Resolution of issues pending from previous versions.

To implement the new version, informatics experts have developed an algorithm through an iterative testing

process with review by the CS Mapping Team. Large amounts of SEER data were run through the algorithm and reviewed for conversion and mapping issues. Testing emphasis was placed on mappings of T, N, M, or stages from AJCC 6th and 7th Editions, and Summary Stage 1977 and 2000 that have been modified. This provided another check on the accuracy of changes for the new version.

For the implementation in registries, the Mapping Team will provide written procedures for preparing records for conversion. We do not anticipate large amounts of time for review will be required at any one registry. For example, there are about 1000 cases expected nationwide for two histology codes for corpus uteri, resulting in very few cases per facility.

A beta version will be available for testing by vendors on October 11. The final release of CS V02.04 is currently scheduled for December 5, 2011, and will include the conversion programs and all documentation. Members of the CSv2 Mapping and IT Teams as well as staff from NCI SEER, CDC NPCR, and IMS will be available for questions throughout the process.

Source: NAACCR-Lserv 9/7/11

Hyperlinked CS Coding Instructions now available

The Coding Instructions hyperlinked to the schemas for Collaborative Stage version 02.03 is now available on the CS website: <http://www.cancerstaging.org/cstage/manuals/coding0203.html>.

The Hyperlinked Coding Instructions were created to make coding CS easier and quicker for cancer registrars. The linked coding instructions will allow the user to more quickly navigate between coding instructions and schemas.

To use the program, download the CS Coding Instructions Program from the above website. There are instructions for downloading and installing the program on your computer on the website.

Users should refer to the “readme.txt” document that is included in the download for how to use the Hyperlinked Coding Instruction. Also available for download are the [Tips for Using the Commenting Tools](#) in Adobe Reader.

Certificate of Excellence Recipients

The following facilities received a certificate for the 2011 Second Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

| Facility | City |
|----------|------|
|----------|------|

Physicians:

Tallman Dermatology
Advanced Dermatology of Butte
Associated Dermatology
Helena Dermatology
Dermatology Associates
Dr. Mark Stewart Dermatology

Billings
Butte
Helena
Helena
Kalispell
Missoula

Hospitals:

Big Sandy Medical Center
Billings Clinic
St. Vincent Healthcare
Bozeman Deaconess Hospital
Rosebud Health Care Center
Frances Mahon Deaconess
Sletten Cancer Center
Kalispell Regional Medical Center
Central Montana Medical Center

Big Sandy
Billings
Billings
Bozeman
Forsyth
Glasgow
Great Falls
Kalispell
Lewistown

Pathology:

Yellowstone Pathology Institute

Billings



Melanoma Conversion Table

Registrars can estimate Clark's level for melanoma cases based on the Breslow's depth. Use the Table below to estimate Clark's level.

| Thickness/Depth | Clark's Level and Definition |
|-----------------------|---|
| In situ; non-invasive | I Involving only the epidermis |
| Up to 0.75 mm | II Invading papillary dermis but not to papillary-reticular dermal interface |
| 0.76 to 1.5 mm | III Invades and expands papillary dermis but no penetration of reticular dermis |
| > 1.5 mm | IV Into reticular dermis but not into subcutaneous tissue |
| Through entire dermis | V Through reticular dermis into subcutaneous tissue |
| Further extension | — Underlying cartilage, bone, skeletal muscle |

Quiz

Source: NAACCR Webinar—Coding Pitfalls—September 2011

1. Malignant melanoma of right upper back diagnosed by punch biopsy. Right supraclavicular node was swollen. Fine needle aspiration was performed and showed no involvement of the node. Wide excision of right upper back lesion showed 1 cm residual melanoma with clear margins. What is the code for CS Lymph nodes Eval?
 - a. 0 - clinical only
 - b. 1 - invasive techniques that do not meet pathologic criteria
 - c. 3 - pathologic
 - d. 9 - unknown
2. Final diagnosis: duct carcinoma in situ of upper outer quadrant of right breast; Bloom Richardson (BR) score 3, low grade. BR score/grade is reportable to your standard setter and cancer committee. What is the code for CS SSF7: Nottingham or BR Score/Grade?
 - a. 030 - score of 3
 - b. 110 - low grade
 - c. 988 - not applicable
 - d. 999 - unknown
3. Final diagnosis is adenocarcinoma of the cecum. Patient treated with hemicolectomy. Pre-operative CEA level documented on lab report as 2.0 ng/ml (normal < 2.5 ng/ml). What is the code for CS SSF1: CEA Interpretation?
 - a. 010 - positive/elevated
 - b. 020 - negative/normal
 - c. 030 - borderline
 - d. 997 - test ordered, results not in chart
4. Digital rectal exam (DRE) documented palpable nodules in left and right lobes of prostate. Results of core biopsies of left and right lobes documented adenocarcinoma in 3 cores on the left side. What is the code for CS Extension - Clinical Extension?
 - a. 200 - involvement in 1 lobe/side
 - b. 210 - involves ½ of 1 lobe/side or less
 - c. 220 - involves more than ½ of 1 lobe/side, but not both lobes/sides
 - d. 230 - involves both side/lobes
 - e. 240 - clinically apparent tumor confined to prostate
5. Needle core biopsy of right breast positive for ductal carcinoma; HER2 IHC is 1+. Modified radical mastectomy positive for ductal carcinoma; HER2 IHC is 0. What is the code for CS SSF8: HER2 IHC Lab Value?
 - a. 000 - score 0
 - b. 010 - score of 1+
 - c. 988 - not applicable
 - d. 999 - unknown